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Journal of Critical Care xxx (xxxx) xxx

Contents lists available at ScienceDirect

Journal of Critical Care

journal homepage: www.journals.elsevier.com/journal-of-critical-care

Critical care leadership during the COVID-19 pandemic

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ARTICLE INFO

Article history:
Received 22 August 2021
Received in revised form 20 September 2021
Accepted 26 September 2021
Available online xxxx

Keywords:
Critical care
Ethics
COVID-19
Leadership
Moral injury

ABSTRACT

The COVID-19 pandemic taxed critical care and its leaders in unprecedented ways. Medical directors, nursing directors, division chiefs and department chairs were forced to lead their staff through a pandemic wrought with personal and professional safety concerns, uncertainty, and more death than most critical care practitioners had ever seen. No leader was fully prepared for the COVID-19 pandemic. Herein, we describe what we believe are the three most important qualities of a leader in times of crisis: presence, transparency, and empathy.

1. Introduction

The COVID-19 pandemic placed an enormous strain on critical care [1] and has taxed its leaders in unprecedented ways. Medical directors, nursing directors, division chiefs and department chairs in critical care were forced to lead their staff through a pandemic wrought with personal and professional safety concerns, uncertainty, moral injury and more death than most critical care practitioners had ever seen [2]. Trust is a crucial quality of a leader [3] but instilling trust during the COVID-19 was difficult due to constantly changing messages regarding testing, infectivity, personal protective equipment (PPE), and challenges with work life balance [4,5].

Despite the recognition of the need for physician leaders and the increase in physician leadership programs over the last decade [6-8], no leader was fully prepared for the COVID-19 pandemic. As physician leaders, we had leadership training, and our hospital had carefully designed disaster management plans, but it was impossible to anticipate the myriad ways in which the COVID-19 pandemic would wreak havoc on personal and professional lives. In those early days of the first surge, any personal fears about our own safety and the safety of our families had to be put aside in order to focus on the tasks at hand – most paramount, to ensure we created policies, procedures, and environments that were as safe as possible so that our teams could compassionately and effectively care for more patients than they were used to, under circumstances they had never encountered. Physician leaders have a duty to both patients and staff, and while we were figuring out how to ensure there were ventilators for our patients, we also had to ensure that our staff were safe and cared for so they could do their jobs well. Herein, we focus on the staff and describe what we believe are the three most important qualities of a leader in times of crisis: presence, transparency, and empathy.

1.1. Presence

We believe that the most important quality of a leader in times of crisis is presence. For us, presence did not just mean being in the moment [9], which is an important quality, but it meant physical presence, the proverbial "boots on the ground," presence. As leaders during the pandemic, days were filled with meetings, urgent calls, and never-ending emergencies. We felt that it was essential that we were visible and accessible in order to routinely check in with all staff – nurses, respiratory therapists, unit coordinators, environmental service workers, residents, fellows, and attendings. We rounded in the mornings and evenings, ensuring that PPE, especially contact precaution gowns were available in the units. We frequently walked through the intensive care units and surge units with candy and coffee to check on staff and made a point to do this at change of shift so we could have face time with both the day and night staff. We handed out meals, we helped clean break rooms, we made coffee for staff. During these informal and impromptu check-ins we heard about challenges and problems that we could fix, but more importantly, we providing a listening ear for staff to unburden themselves about their fears, their challenges at work, and their challenges at home. During these times we heard about and also experienced ourselves the moral injuries that staff

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https://doi.org/10.1016/j.jcrc.2021.09.015
0883-9441/

were facing. Moral injury occurs when staff must participate in or witness events that oppose their moral beliefs or moral expectations [10,11]. Staff were distraught over the policies that barred visitors during the early days of the pandemic and many felt forced to provide potentially inappropriate care [12] as they thought it took a long time for families to accept that patients were not getting better. As leaders, we couldn't always fix what they brought forward, but actively listening and being present in the moment was crucial. Often just as important. Acknowledging the moral injury and listening was necessary [13]. Listening is not only powerful but can be healing [14]. Being present to help care for patients, help experience the loss, and celebrate the wins was so important [15].

We ensured that despite our busy administrative schedules, we worked clinically alongside our peers. We never asked anyone to do anything that we would not do ourselves, and early on we insisted that we were the ones doing the highest risk procedures, such as bronchoscopies. In addition to clinical time, we created safe spaces where we made ourselves available for impromptu conversations about difficult cases, or challenges at home, or just acting as a support while staff cried. These spaces turned into physical and emotional spaces of consolation, healing, and celebration. Towards the end of the first surge, we created spaces of celebration after work where people could gather safely, share a meal and drink together, and talk, laugh, and cry.

1.2. Transparency

Transparency demands accountability and openness [16]. As leaders we have a duty to be honest with those we lead. During the early days of the pandemic there was appropriate ambiguity and uncertainty due to the novel nature of the infectious agent, which lead to anxiety and at times confusion, but we embraced the uncertainty and were totally transparent about it. As doctors, we are used to dealing with uncertainty in clinical encounters, so we embraced this too when dealing with our staff. We helped them to not only tolerate uncertainty but to embrace it [17]. Our PPE guidance changed frequently as the medical community learned more about the virus and its transmissibility. Additionally, our treatments changed as we learned how best to combat COVID-19. It was difficult at times to not know the answers to everything we were asked, or to be the ones who were constantly changing the policies, and the plans. We assured those whom we led that we would always be honest and transparent. Our transparency was the constant during ever-changing national guidelines, hospital policies, recommended treatments, and PPE requirements.

1.3. Empathy

Empathy was described by the late 19th century psychologist Theodore Lipps as “feeling one's way into the experience of another” [18]. The importance of empathy cannot be overstated, and an empathic leader can inspire and empower those he or she leads [19]. During the pandemic, critical care physicians, nurses, and other clinical staff were forced to manage the physical stress of long hours, greater numbers of patients, and delivering care in clunky and uncomfortable PPE. Staff were also required to manage moral injury and significant emotional stress as well, such as concerns about lack of adequate PPE, lack of key medications, and increasing numbers of end of life conversations and situations [2,20]. There were high rates of psychological distress [21] and fear, anxiety, and worry throughout the pandemic. It has been shown that empathy can counteract feelings of worry and fear [5].

Empathy, a teachable skill, is considered a core skill in medicine [22]. As physicians, we strive to show empathy to our patients and their families, but it is just as important to have empathy for those we lead. Empathy has been described as “an accurate understanding of the experience of the sufferer [22,23]” and because we were present with them and going through this pandemic beside them, we had that shared understanding. Our presence on the front lines shoulder to shoulder with those we led helped us to understand their suffering. Although every personal situation – home schooling, sick parents, jobless partners – was unique, we were able to identify with the personal challenges and clearly understand the professional challenges as we too were living them. We showed our empathy through our presence and availability and through our transparency. We had a “door is always open” policy and additionally created spaces for our teams to voice their concerns and be heard. We had frequent virtual town halls and dedicated faculty and staff meetings. We sent nightly emails to highlight the shared experiences we all had, thanking people for their work, and telling them we understand what they were going through.

2. Conclusion

Although the first and second surges have come and gone, the pandemic is far from over. In many ways these subsequent surges are more difficult. We as leaders are tired, our workers are tired, and we are faced with societal challenges with vaccines and masks, threat of new variants, continued supply chain shortages, and new workforce shortages. We know these difficulties will likely worsen before they abate. Continuing to lead anchored by the three key principles of presence, transparency, and empathy will ensure that we emerge from this prolonged crisis with the best possible outcomes for both our patients and our teams.

Funding

We have no financial disclosures.

Declaration of Competing Interest

We have no conflicts of interest.

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